

# Medicare Prescription Drug Coverage

## **“Information for Dual Eligible individuals” \***



### **A 2007 Guide Produced by the CHOICES Program**

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On January 1, 2006 Medicare began a new program to pay for prescription drugs for people who have Medicare Part A and/or Part B. This new program is known as “Medicare Rx.” It is also called “Medicare Part D.”

If you currently have both Medicare and Medicaid, you are already getting most of your prescription drugs through a Medicare prescription drug plan. You probably already know how your plan works, but you can read this if you still have any questions. This Guide explains the Extra Help “redeeming” process that occurred in the fall of 2006. It also discusses the “benchmark” plans for 2007.

**Special Section on Medicaid Spenddown!** See page 11 to get important information for people on a Medicaid spenddown.

**Special Information for Newly Granted Dual Eligible Individuals!** If you are just getting Medicare and Medicaid for the first time, please see page 14 for information on getting your initial prescriptions!

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\* Seniors and people with disabilities who have both Medicare and Medicaid.

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## **1. What is Medicare Prescription Drug Coverage?**

On January 1 2006, Medicare began a new program to pay for most outpatient prescription drugs, insulin and insulin supplies, and “stop smoking” drugs. It is a program for everyone who has Medicare. It is also known as “Medicare Rx” and “Medicare Part D.”

**If you have both Medicare and Medicaid (Title 19), the Medicare prescription drug program (rather than Medicaid) will pay for most of your prescription drugs.** Medicaid will still pay for some of your drugs, and it still pays for all your other medical and hospital needs that Medicare does not cover.

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## **2. How is the program administered?**

Medicare doesn’t administer the program directly. Instead, it contracts with private companies to provide the coverage. **If you have both Medicare and Medicaid (Title 19), you are probably already enrolled in a prescription drug plan offered by one of these private companies.** You may have selected a plan on your own, or Medicare may have auto-enrolled you in a plan at the end of 2005.

In 2007, there will be 51 free-standing **PDPs** (prescription drug plans) offered in Connecticut. The PDPs just offer prescription drug coverage.

There are 24 **MA-PDs** (Medicare Advantage Prescription Drug Plans). MA-PDs, which may be HMOs or Private Fee For Service plans, offer hospital and medical coverage in addition to prescription drug coverage. MA-PDs are options for people who want to receive all of their health care under a

single provider. Some of these plans only offer coverage in certain counties within Connecticut.

There are also 9 Medicare Special Needs Plans (**SNPs**). SNPs are MA-PD plans that have special rules for enrollment. They are all limited to people who have Medicare and Medicaid ("dual eligibles"). Some have other requirements, such as living in an institution or having certain chronic or disabling conditions. Most SNPs only offer coverage in certain counties within Connecticut.

Ask CHOICES for the Enrollment Guide that describes all of the Connecticut PDPs, MA-PDs and SNPs in detail.

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### **3. What drugs does Medicare cover?**

Medicare covers most outpatient prescription drugs, insulin and insulin supplies, and "stop-smoking" drugs. Medicare-approved plans are required to offer a choice of at least two drugs in each of 146 categories of drugs. Medicare-approved plans are also required to cover substantially all drugs in the following six categories of drugs: anti-depressants, anti-psychotics, anti-convulsants, anti-cancer, immuno-suppressants and HIV/AIDS.

Certain drugs are not covered by any of the Medicare prescription drug plans. These "**excluded**" drugs include: barbiturates, benzodiazepines, drugs exclusively for weight loss or gain, over-the-counter drugs, and drugs that are covered by Medicare Part A or Part B. If you are a dual eligible individual, Medicaid will continue to pay for these excluded drugs.

Each Medicare prescription drug plan offers its own selection of covered drugs, called a **“formulary.”** Each plan has a different formulary. **Your plan will only pay for Medicare-covered drugs that are on its formulary. Your plan will not pay for excluded drugs!** However, if you are a dual eligible person (one who has both Medicare and Medicaid), the State of Connecticut will “wrap around” your plan’s coverage to pay for some non-formulary drugs. Read more about the Connecticut wrap-around at Questions 4 and 5.

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#### **4. How do I pay for drugs that my plan doesn’t cover?**

Some drugs are coverable by Medicare but may not be on your plan’s formulary. These are referred to as “non-formulary” drugs. Other drugs are “excluded,” i.e., Medicare won’t pay for them, and so they won’t be on any plan’s formulary. **Medicaid will continue to pay your excluded drugs, provided they were covered by the State before January 1, 2006.**

In addition, the **State of Connecticut “wraps around”** the Medicare prescription drug program to provide coverage of non-formulary drugs for dual eligible individuals. **If you are a dual eligible, the State (Medicaid) will pay for your non-formulary drugs, provided these are drugs that Medicaid covered prior to January 1, 2006.** Medicaid will also pay for formulary drugs that your plan subjects to “prior authorization” restrictions (meaning your doctor must contact the plan to get permission for the prescription).

However, Medicaid will not pay for a prescription that your plan denies because of quantity limits or days supply. (For example, if your doctor

prescribes 30 pills per month and your plan limits the drug to 14 pills per month.)

To get a drug that your plan has denied because of quantity limits, days supply or step therapy, you will need to ask your plan for an Exception, which is the first step of the Medicare prescription drug program Appeals process. CHOICES can refer you for free help to file an Exception request.

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## **5. What is “Extra Help”?**

Extra Help, a subsidy administered by the Social Security Administration, helps people to pay for their Medicare prescription drug costs. As a dual eligible person, you are eligible for a “full subsidy” Extra Help. You do not have to pay for premiums and deductibles and you do not have a gap in coverage sometimes called the “donut hole.” In 2007, the full subsidy also limits co-pays to a maximum of \$2.15 for generics and \$5.35 for brand name drugs.

In addition to the Extra Help subsidy, because you are a dual eligible, you qualify for the **State of Connecticut “wrap around” program. This means that your pharmacy will bill the State (Medicaid) for all of your co-pays. You will not have to pay anything for your prescriptions.**

If you were on Medicaid in 2005 you automatically qualified for Extra Help in 2006. You did not need to apply for it separately. **Your Extra Help will continue in 2007 if you are still on Medicaid.** If you are no longer on Medicaid, or if you had certain types of changes in your situation, you probably received a letter saying that you lost your eligibility for Extra Help or that the amount of your Extra Help will change.

**If you lost your eligibility for Extra Help and think you may still qualify, you should reapply immediately.** If you don't reapply and qualify for Extra Help, you may have to pay premiums, deductibles and co-pays for your prescription drugs 2007. **NOTE:** Because people who lose their Extra Help may face an increased premium, Medicare will allow them to switch to a lower cost plan through March 31, 2007. This limited opportunity to change plans is called a Special Election Period (SEP).

If the amount of your Extra Help has changed, you may have to pay something toward your monthly premium and the amount of your co-pays may change. Be sure to follow instructions in your letter if you think this change is incorrect. Ask CHOICES if you need help with this.

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## **6. Can I change my plan?**

Yes, as a dual eligible person, you can change plans at any time. Your change will be effective the first day of the month following the month you made the change.

Read more about changing plans below.

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## **7. How do I change my plan?**

To change plans, you just need to enroll in the new plan that you want. You don't need to disenroll from your existing plan! Your enrollment in the new plan will automatically cancel your enrollment in your former plan. **To avoid delays or problems with enrollment, it is strongly advised that you enroll in your new plan before the 8<sup>th</sup> of the month.** For example, if you want to be in your new plan by January 1, 2007, you should enroll by

December 8, 2006. You can enroll in your new plan by calling the plan directly, calling 1-800-MEDICARE, or calling CHOICES at 1-800-994-9422.

Medicare recently mailed you the “Medicare & You 2007” handbook, which lists all of the plans in Connecticut. You should also get a copy of the CHOICES Enrollment Guide. It also gives you information about the plans in Connecticut and suggests what to do to be sure you get into a plan that meets your needs.

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## **8. Do I have to do anything if I am happy with my existing plan?**

Before you decide whether to stay with your existing plan you need to find out if your plan will change in 2007. The way to find out is to study the information your plan sent you at the end of October in its Annual Notice of Change (ANOC).

The ANOC includes information about changes to premium and deductible amounts, changes in “donut hole” coverage, and changes to formularies, including the addition of utilization management tools such as prior authorization, quantity limits and step therapy on any of its formulary drugs. The ANOC also includes information about changes to tiered co-pay amounts, including the placement of some drugs on a different tier. **People who are limited to a “benchmark” plan should check to be sure their plan still qualifies as a benchmark plan in 2007.** Read more about benchmark plans at Question 9.

<b>IMPORTANT:</b> If a plan granted an indefinite Exception in 2006 that it does not intend to continue in 2007, the plan must notify the member of this
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change. This notice may be included in the ANOC or it may be sent in a separate notice mailed by the end of October.

If you remain satisfied with your plan after reading the ANOC you do not need to do anything. In most cases, your membership in the plan will automatically continue into 2007. **The exception to this is if you were auto-enrolled in a benchmark plan that is no longer a benchmark plan in 2007. If this is the case, Medicare will reassign you to another plan.** Read more about this below.

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## **9. What is a benchmark plan?**

A benchmark plan is one that offers standard (rather than enhanced) benefits and has a monthly premium at or below the regional average monthly premium. The 2007 regional average monthly premium is \$27.35. Fifteen (15) of the 51 PDPs in Connecticut are benchmark plans in 2007. You can get a list of these from CHOICES.

If you are a dual eligible person who was auto-enrolled into a plan in 2006, you are probably in a benchmark plan. If your plan no longer qualifies as a benchmark plan in 2007, you will be allowed to remain in the same plan if the new premium is no more than \$2 over the benchmark, i.e., no more than \$29.35.

If Medicare assigned you to a plan that is no longer a benchmark plan in 2007, Medicare will send you a notice of reassignment in November. **The notice of reassignment will be on blue paper.** If the company that sponsors your current plan has another plan that qualifies as a benchmark plan, you

will be reassigned to that plan. If the sponsor does not have a qualifying benchmark plan in your area, Medicare will randomly assign you to another benchmark plan. **Remember, as a dual eligible individual you can change plans if you do not like the plan you have been reassigned to.**

**NOTE:** Pacificare merged with United Health Care and continues to offer plans under this new company. If you were randomly assigned to a Pacificare benchmark plan in 2006, Medicare will reassign you to a United Health Care benchmark plan so you continue to have coverage in 2007.

**IMPORTANT!**

To respect individual choice, Medicare won't reassign people who:

1. Joined a plan on their own in 2006, rather than being auto-enrolled by Medicare, or
2. Switched to another plan after Medicare auto-enrolled them in a plan in 2006, or
3. Were enrolled in a plan by ConnPACE.

## **SPECIAL INFORMATION FOR PEOPLE ON A MEDICAID SPENDDOWN**

**What is spenddown?** If your income is too high to qualify for Medicaid, you may be on a Medicaid “spenddown.” During this time, your medical expenses, including your prescription drug costs, are subtracted (“spent down”) from your income until your income falls below the allowable Medicaid income limit. The more medical expenses you have, the faster you reach your spenddown and become eligible for full Medicaid benefits.

**How do I get help paying for my prescription drugs while I am on spenddown?** In Question 5 we told you about getting Extra Help to pay for your Medicare prescription drugs. **Once you qualify for Medicaid you will get this Extra Help automatically and it will continue for a year, even if you go into another spenddown period.** While you are on spenddown and getting this Extra Help, you will pay a maximum of \$2.15 (generic) or \$5.35 (brand name) for your drugs. **However, only the amount that you pay for your drugs (the \$2.15 or \$5.35), not the full cost of the drugs, can be applied against your spenddown.**

**How will I meet my spenddown if I have Extra Help?** Because of the Extra Help you are getting, you may not meet your spenddown as fast as you used to. In some cases, if you have a very high spenddown and relatively low prescription drug and other medical costs, you may not ever meet your spenddown. However, you will continue to pay only very small co-pays for your drugs while you are on spenddown. Because you are paying very little for your drugs, you’ll probably keep more of your own money to spend on other things. However, you may need to use some of this money to meet your other medical needs that Medicaid used to pay for.

### An Example of Medicaid Spenddown

**Before January 1<sup>st</sup> 2006 (without Extra Help):** Sam's gross monthly income was \$884. DSS disregarded the first \$207 of Sam's income, so only \$677 was counted against the Medicaid income limit ( $\$884 - \$207 = \$677$ ). The monthly Medicaid income limit in his area of the state is \$477. Therefore, Sam had \$200 in "excess income" each month ( $\$677 - \$477 = \$200$ ). He needed to incur this amount in medical bills before he could qualify for Medicaid. Sam spent \$225 each month out-of-pocket for medical expenses (\$150 for 10 generic prescriptions and \$75 to the doctor). The actual spenddown period in CT is six months so we are going to multiply all of Sam's income and medical expenses times 6 months to show how his spenddown will work.

	Monthly		Over a 6-month period
Sam's countable income	\$677	X 6 months	\$4,062
Sam's Medicaid income limit	\$477	X 6 months	\$2,862
Sam's "excess income" (\$677 - \$477 = \$200)	<b>\$200</b>	X 6 months	<b>\$1,200</b> (Sam's spenddown amount)
Sam's medical bills (\$15 each for 10 generic prescriptions and \$75 for a doctor's visit.	\$225	X 6 months	\$1,350

Because he incurred at least \$1,200 in medical expenses, Medicaid was granted and DSS picked up \$150 of his medical expenses ( $\$1,350 - \$1,200 = \$150$ ). In addition to the \$1,242 that the Department disregarded up front ( $\$207 \times 6 \text{ months} = \$1,242$ ), this left Sam with \$2,862 to spend on other needs ( $\$4,062 - \$1,200 = \$2,862$ ).

**After January 1, 2007 (with Extra Help):** In the same circumstances, but with Extra Help, Sam is now paying only \$21.50 ( $\$2.15 \times 10 = \$21.50$ ) for the same 10 generic prescriptions that used to cost \$150 without Extra Help. Because he's spending less, it's going to take longer for him to meet his spenddown. At the same time, however, he has more of his own money left over each month. The table below shows how much Sam had left to spend on other needs prior to January 1, 2006, and with the Extra Help he receives under the Medicare prescription drug plan after January 1, 2007. *With Extra Help, Sam has \$621 more left in his pocket at the end of a six-month period ( $\$3,483 - \$2,862 = \$621$ ).*

	Before 1/1/06	With Extra Help After 1/1/07
Six-month countable income	\$4,062	\$4,062
Six-month Medicaid income limit	\$2,862	\$2,862
Six-month "excess income" (his spenddown amount)	<b>\$1,200</b>	<b>\$1,200</b>
Costs for 10 generic prescription drugs	\$900 ( $\$150/\text{month} \times 6 = \$900$ )	\$129 ( $\$2.15$ co-pay each for 10 generic prescription $\times 6$ months)
Other medical expenses over 6 months ( $\$75 \times 6$ )	\$450	\$450
Total medical expenses	<b>\$1,350</b> ( $\$900 + \$450$ )	<b>\$579</b> ( $\$129 + \$450$ )
Eligible for Medicaid?	Yes	No
Sam's total out-of-pocket costs	\$1,200	\$579
Amount Sam has left for other expenses (in addition to the \$1,242 he has leftover from the up front unearned income disregard)	<b>\$2,862</b> ( $\$4,062 - \$1,200$ )	<b>\$3,483</b> ( $\$4,062 - \$579$ )

**What if I have ConnPACE during my spenddown period?** If you have ConnPACE, ask your CHOICES counselor for a Guide that explains how ConnPACE works with the Medicare prescription drug program and the Medicaid spenddown.

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## **SPECIAL INFORMATION FOR NEWLY GRANTED DUAL ELIGIBLE INDIVIDUALS**

Dual eligible individuals are people who have both Medicare and Medicaid (Title 19). You are a “newly granted” dual eligible if:

1. You have Medicaid and become eligible for Medicare because you turned 65 or because you qualified for Social Security Disability Insurance (SSDI) for 24 months; or
2. You have Medicare and become eligible for Medicaid (Title 19).

**If you have Medicaid and become eligible for Medicare:** You will get a Notice of Action from the Department of Social Services. The Notice will tell you that Medicaid will no longer pay for your prescription drugs because you are now eligible for Medicare coverage of prescription drugs. (Medicaid will continue to cover all of your other medical needs that Medicare does not cover.) About three months before you get this Notice, the Department of Social Services will notify Medicare that you will soon turn 65 (or meet the 24-month disability requirement). When Medicare gets this information, they will send you information about the Medicare prescription drug program. Medicare will tell you that you need to enroll in a prescription drug plan. Medicare will randomly assign you to a plan if you do not select one on your own. You should be in your new Medicare prescription drug plan by the time your Medicaid prescription drug coverage ends. If this does not happen, you can go to your pharmacy and ask that they do a “Wellpoint POS facilitated enrollment” to enroll you in a plan

immediately. **If there are any problems with this and you cannot get your prescriptions, call CHOICES right away.**

**If you have Medicare and become eligible for Medicaid:** If you have Medicare you are probably already in a Medicare prescription drug plan. However, your plan needs to be informed that you are now on Medicaid so you will not have to pay a premium and will not be overcharged for co-pays at the pharmacy. The Department of Social Services will notify Medicare that you are on Medicaid, and Medicare will subsequently inform your plan that you are on Medicaid and are automatically entitled to the Extra Help discussed at Question 5. If this notification does not happen timely, you will need to contact your Medicare prescription drug plan and tell them you are on Medicaid. They will probably need to see a copy of your Medicaid award notice. You will also need to show your plan membership card and your Medicaid award notice at the pharmacy. **Contact CHOICES if you need any help with this process.**

**End of special sections**

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## **10. Important dates in late 2006 and early 2007.**

**Mid-October 2006** – Medicare’s on-line Plan Finder tool, which allows people to identify and compare PDPs and MA-PDs in their area, is updated with 2007 plan information. It also allows people to enroll in a plan on-line. To access the Plan Finder go to: [www.medicare.gov](http://www.medicare.gov).

**End of October 2006** - Plans mail out their Annual Notice of Change (**ANOC**) informing members of any changes to premiums, formularies, cost-sharing, Extra Help subsidy status, and continuing exceptions for the coverage of non-formulary drugs.

**Late October - early November 2006** - Medicare mails out the “Medicare & You 2007” Handbooks. The handbook provides general information about Medicare, including services covered by Medicare and the rights of Medicare beneficiaries. It also contains detailed information about PDPs, MA-PDs and SNPs available in your geographic area.

**November** - Medicare notifies people who were randomly assigned to a plan in 2006 if they are being reassigned to another benchmark plan in 2007.

**Mid-November 2006** - Employers and unions that provide benefits to Medicare-eligible individuals and dependents must provide members with notice, before November 15, whether the prescription drug coverage they offer is “creditable,” i.e., whether it is at least as good as the Medicare prescription drug program.

**November 15, 2006 – December 31, 2006** - The Annual Coordinated Enrollment Period. Medicare-eligible individuals can enroll in or change

their PDP. With the exception of dual eligible individuals and MSP recipients (who can change plans at any time), or other individuals who qualify for a Special Enrollment Period (SEP), people are locked into their PDP for the rest of the calendar year.

**December 8, 2006** – The date by which people who wish to change plans should enroll in their new plan in order to ensure coverage by January 1, 2006.

**January 1, 2007** - New Medicare prescription coverage begins for 2007.

**January 1, 2007 – March 31, 2007** - The MA Open Enrollment Period. Medicare-eligible individuals can change their MA or MA-PD plan. With the exception of dual eligible individuals and MSP recipients (who can change plans at any time), or other individuals who qualify for a Special Enrollment Period (SEP), people are locked into their MA or MA-PD plans for the rest of the calendar year. People cannot add or drop prescription drug coverage during this period.

**March 31, 2007** – The end of the Special Election period for beneficiaries notified that they no longer qualify for Extra Help.

## 11. Where Can I Get More Information?

Call CHOICES (1-800-994-9422) to speak to a counselor at the Area Agency on Aging serving your area of the state. CHOICES counselors are trained and certified to assist you with your Medicare issues and concerns. They can also help with comparing and enrolling in a Medicare prescription drug plan and getting Extra Help to pay for your premiums, deductibles, and co-pays.

You can also get more information from these on-line sources:

- State of CT Department of Social Services:  
[www.ct.gov/medicarerx](http://www.ct.gov/medicarerx)
- Medicare: [www.medicare.gov](http://www.medicare.gov)
- Social Security: [www.socialsecurity.gov](http://www.socialsecurity.gov)
- Center for Medicare Advocacy: [www.medicareadvocacy.org](http://www.medicareadvocacy.org)
- Department of Social Services, Aging Services Division:  
[www.ct.gov/agingservices](http://www.ct.gov/agingservices)

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This publication is not a legal document. The official Medicare provisions are contained in the relevant laws, regulations and rulings.

This information is available in alternative formats. Call 1-800-994-9422. TDD/TTY users call 1-800-842-4524.